N O R T H C A R O L I N A G E N E R A L A S S E M B L Y

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

SUBCOMMITTEE ON MENTAL HEALTH

FINAL REPORT
TO THE
FULL COMMITTEE

JANUARY 2013

TRANSMITTAL LETTER

The Subcommittee on Mental Health, respectfully submits the following report to the Joint Legislative Oversight Committee on Health and Human Services pursuant to S.L. 2012-142, Sec. 10.11 as amended by S.L. 21012-145, Sec. 3.4.

Representative Justin Burr
Co-Chair

Senator Louis Pate
Co-Chair

SUBCOMMITTEE MEMBERSHIP

THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON
HEALTH AND HUMAN SERVICES
SUBCOMMITTEE ON MENTAL HEALTH

MEMBERSHIP LIST
2011- 2012

Senator Louis Pate – Co-Chair

Senator Doug Berger

Senator Stan Bingham

Senator Fletcher Hartsell, Jr.

Senator Tommy Tucker

Representative Justin Burr – Co-Chair

Representative Marilyn Avila

Representative William Brisson

Representative Hugh Blackwell

Representative Bert Jones

STAFF

Jan Paul, Research

Patsy Pierce, Research

Joyce Jones, Bill Drafting

Joey Stansbury, Committee Clerk

Denise Thomas, Fiscal Research

Barbara Riley, Research

Susan Barham, Research

OVERVIEW OF SUBCOMMITTEE PROCEEDINGS

The Subcommittee on Mental Health Services of the Joint Legislative Oversight Committee on Health and Human Services held four meetings between September 10, 2012, and December 18, 2012.

September 10, 2012

Review of Law Establishing Subcommittee Charge
Denise Thomas, Fiscal Research

Overview of Major Mental Health Reform
History and Major Legislative and Policy Changes 2001 – Present
Jan Paul, Research

Impact on State Facilities and Community Psychiatric Hospitals
Ms. Laura White, Team Leader Psychiatric Hospitals
Division of State-Operated Healthcare Facilities

LME Perspective on Impact of Major Reform/Policy Changes
Pam Shipman, CEO PBH

Impact of Mental Health Policy on Law Enforcement
Sheriff Tony Perry, Camden County, President, NC Sheriffs' Association

October 8, 2012

Community Hospital Panel
Sandhills/Randolph Co. Psychiatry Contracts
Anthony Carraway, M.D., Sandhills LME/MCO
Kenny Burrow, CEO, Therapeutic Alternatives
Tremonteo Crawford, RN, MSN, Chief Nursing Officer, Randolph Hospital, Inc.

Durham Center Access (Facility-based Crisis)
Trish Hussey, Executive Director, Freedom House Recovery Center
Anita A. Daniels, MSW, LCSW, CSI, LCAS, Director, Durham Center Access
Logan Graddy, M.D., Medical Director, Freedom House Recovery Center

Presbyterian Hospital Peer Support Specialist Program
D. Dontae Latson, MSSA, LCSW, Director
Cherene Allen-Caraco, Mecklenburg Promise

Three-Way Contract Hospitals Overview
Denise Thomas, Fiscal Research

Hospitals with Three-way Contracts
Stephanie Greer, MBA, Director, Inpatient and Outpatient Behavioral Health Programs
Charles A. Cannon Jr. Memorial Hospital, Linville, NC
Victor Armstrong, Behavioral Medicine Program Manager
Alamance Regional Medical Center, Burlington, NC

State-Community Hospital-LME/MCO Solution-Based Planning
Dr. Beth Melcher, Chief Deputy Secretary, DHHS
Hugh Tilson, NC Hospital Association
Pam Shipman, Cardinal Innovations LME/MCO

December 10, 2012

Reviewing the Map: History and Process of Determining Facilities' Catchment Areas and How Current Catchment Areas Affect Local Communities
Laura White, Team Leader Psychiatric Hospitals, Division of State-Operated Healthcare Facilities

Overview of the Involuntary Commitment Process
Mark Botts, J.D., UNC School of Government

Telepsychiatry
Shelia Davies, MPA, Project Director, Albemarle Hospital Foundation
Edward Spencer, M.Ed., MSW, Program Manager, DMH Telepsychiatry Program, South Carolina Department of Mental Health

Three-Way Contract Payments
Dr. Beth Melcher**,** Chief Deputy Secretary, DHHS

Services for Members of the Military and Veterans with PTSD
Kimberly Alexander-Bratcher, Project Director, NCIOM
Harold Kudler, M.D., Mental Health Coordinator, Veterans Integrated Service Network, Durham VA Medical Center
Stephanie Nissen, LPC, LMHC, North Carolina National Guard

Subcommittee Discussion and Review of Draft Subcommittee Report

December 18, 2012

Subcommittee Review of Draft Subcommittee Report

SUMMARY OF SUBCOMMITTEE PROCEEDINGS

This section of the report provides a brief summary of the Subcommittee meetings. It is not intended to be a complete, official record of those meetings. However, there is an official record of the Subcommittee's meetings, including minutes and handouts distributed to the Subcommittee members, in the Legislative Library.

September 10, 2012

Co-Chairmen Senator Pate and Representative Burr welcomed members to the Subcommittee meeting and Denise Thomas, Fiscal Research reviewed the 2012 budgetary provisions establishing the charge of the Subcommittee. Jan Paul, Staff Attorney, Research, reviewed the history of State and county mental health services, focusing on major reform efforts since 2001. Ms. Paul discussed the State's responses to the Olmstead decision and other federal initiatives and mandates over the past decade.

Laura White, Hospital Team Leader for the Division of State-Operated Healthcare Facilities, DHHS, explained the impact of reform on the State facilities and community psychiatric hospitals. Ms. White included the following information during her presentation:

- After the Olmstead decision, DHHS and the Division of MH/DD/SAS developed a plan to expand community capacity and then reduce the size of the state psychiatric hospitals.
- Five hundred beds were closed rather than the seven hundred originally established. Among the beds closed were the adult long term, geriatric long term, and skilled nursing beds.
- $28 million was provided to the Local Management Entities (LMEs) on a one-time and recurring basis in order to support the services established for those being discharged from hospitals into the community as well as those who otherwise would have needed those hospital beds.

Pam Shipman, CEO of Piedmont Behavioral Health, provided a perspective on how major reform and policy changes have affected the LMEs, including the positive aspects of the managed care system which is being expanded via the 1915(b)/(c) waiver throughout the State.

Tony Perry, Sheriff of Camden County and President of the North Carolina Sheriffs' Association, addressed the impact of mental health reform on the law enforcement community. He said that the responsibility of transporting individuals with behavioral health needs to and from facilities is a State mandated law and that an officer could spend as much as 20 to 24 hours in transporting and wait time.

October 8, 2012

Anthony Carraway, Sandhills LME/MCO, Kenny Burrow, Therapeutic Alternatives, and Tremonteo Crawford Randolph Hospital, Inc., described the collaborative process among their agencies to provide psychiatric assessments and consultation to persons coming to the emergency department (ED) at Randolph Hospital. The presenters stated wait time in the ED has been reduced with the implementation of this service.

Trish Hussey, Executive Director, Freedom House Recovery Center, Anita A. Daniels, Director, Durham Center Access, and Logan Graddy, Medical Director, Freedom House Recovery Center, described the services provided by the Durham Access Center. The Durham Access Center is a crisis center providing these services to approximately 200 individuals per month with an average stay of 20 hours. Services include:

- 24-hour crisis facility
- 16 facility-based crisis beds – short-term stabilization for adults – alternative to inpatient hospitalization
- 11 23-hour crisis evaluation observation rooms (one for juveniles) – short-term intensive intervention to stabilize acute or crisis situations
- Telephone and face-to-face screening, triage and referral to community providers

Dontae Latson, MSSA, LCSW, Director, and Cherene Allen-Caraco, Mecklenburg's Promise, explained what "peer support" means and provided examples of different peer support models. They also discussed outcomes research related to providing peer supports to persons with mental health needs.

Denise Thomas, Fiscal Research, explained what a three-way contract between a community hospital, an LME/MCO, and DHHS entails. These contracts support community hospital beds for persons with mental health needs. Three-way contract managers, Stephanie Greer, Director, Inpatient and Outpatient Behavioral Health Programs, Charles A. Cannon Jr. Memorial Hospital, Linville, NC, and Victor Armstrong, Behavioral Medicine Program Manager, Alamance Regional Medical Center, Burlington, NC, described how the contracts are working for their hospitals. The contract managers indicated that the delay in payment from the State was reducing their ability to provide hospital beds to persons with mental illness in their communities.

Dr. Beth Melcher, DHHS, Hugh Tilson, NC Hospital Association, and Pam Shipman, Cardinal Innovations LME/MCO, shared concerns which had been expressed in meetings to address the problems created when persons with mental health needs repeatedly use EDs for all health and mental health needs.

December 10, 2012

Laura White, Hospital Team Leader, Division of State Operated Healthcare Facilities, Department of Health and Human Services, presented on the history of catchment areas/ admissions regions of the state psychiatric facilities. The hospital catchment areas were first

established in the N.C. Administrative Code in 1976, with the last major change to the admission regions coming in 2009, which created three rather than four state hospital regions in preparation for consolidation of Dorothea Dix Hospital and John Umstead Hospital into Central Regional Hospital. She outlined the hospital services subject to admission regions as well as those not subject to admission regions. Ms. White provided a map of the three regions and explained the criteria, including population and geographic proximity, used in determining equitable catchment areas, and described the transition planning process.

Mark Botts, J.D., UNC School of Government, provided an overview of the involuntary commitment process (IVC). His presentation focused on the criteria and procedure for IVC, and specifically what happens after a clinician or a layperson petitions for IVC, what occurs after a magistrate issues a custody and transportation order, and the process for transporting, examining, and affording due process to an individual for whom an involuntary commitment is sought.

Shelia Davies, MPA, Director, Albemarle Hospital Foundation, provided an overview and explained the goals of the North Carolina Hospital Telepsychiatry Network. She explained that the project was created to establish a hospital based two-way, real time, interactive audio and video network to improve the delivery of acute behavioral health care in hospitals and reduce the cost of delivering such care.

Edward Spencer, M.Ed., MSW, Program Manager,Telepsychiatry Program, South Carolina Department of Mental Health, described South Carolina's behavioral health partnership program to provide timely psychiatric assessment and rapid initiation of treatment, increased quality of care, reduced lengths of stay, comprehensive discharge planning, and savings to the hospital and community.

Dr. Beth Melcher**,** Chief Deputy Secretary, DHHS, addressed concerns previously expressed by Subcommittee members regarding late payments by DHHS to LMEs on three-way contracts designed to increase bed capacity within the community by paying hospitals for short-term care of mental health patients in crisis. She discussed adequacy of the payment rate, billing issues, the proposed payment process, and claims and contract spending.

Kimberly Alexander-Bratcher, Project Director, North Carolina Institute of Medicine, discussed the findings and recommendations of the NCIOM Task Force on Behavioral Health Services for the Military and Their Families. The General Assembly had asked the NCIOM to study the adequacy of mental health, developmental disabilities, and substance abuse services funded with Medicaid and state funds available to active and reserve component members of the military, veterans, and their families and to determine any gaps in services.

Harold Kudler, M.D., Mental Health Coordinator, Veterans Integrated Service Network, Durham VA Medical Center, described selected N.C. military/veteran demographics, various pervasive mental health problems reported among veterans, ongoing N.C. and national initiatives, treatment and provider training, and key steps in building military-friendly practices and health systems.

Stephanie Nissen, LPC, LMHC, North Carolina National Guard, outlined the Integrated Behavioral Health System. Ms. Nissen discussed the most common clinical and non-clinical referrals of service members, and current gaps in services for members of the military seeking treatment and assistance related to Post Traumatic Stress Disorder and other mental health conditions

Following the presentations, there was subcommittee discussion and a review of the subcommittee's draft findings and recommendations. The subcommittee members were informed that the final report would be discussed and voted upon at the next meeting on December 18, 2012.

December 18, 2012

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health met on Tuesday, December 18, 2012, to discuss its final report. Following discussion and the adoption of several amendments, the report was approved.

FINDINGS AND RECOMMENDATIONS

FINDING 1: The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, heard from the Department of Health and Human Services, Division of State Operated Healthcare Facilities (DSOHF), about the total number of licensed and staffed psychiatric hospital beds in both community and operating state hospitals. DSOHF indicated that the total number of beds has decreased since 2001. The Subcommittee also learned that the average length of stay for individuals presenting to community hospital emergency departments (EDs) with a behavioral health crisis was 15 hours, 52 minutes. Over half of these patients (53%) were discharged to home or self-care. The Subcommittee finds that even though North Carolina's total population continues to increase, the psychiatric hospital bed census has decreased and that the operation of State psychiatric facilities is needed as a part of the continuum of mental health care and to help decrease the length of stay in EDs.

RECOMMENDATION 1: The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services encourage the General Assembly to direct the Department of Health and Human Services to (i) determine the cost of increasing the number of beds in State psychiatric hospitals, (ii) explore the possibility of creating a south central mental health region to include at least Anson, Cabarrus, Davidson, Mecklenburg, Montgomery, Moore, Randolph, Richmond, Rowan, Scotland, Stanly, and Union counties, and (iii) investigate the possibility of placing a new psychiatric facility in this region of the State. The Department shall provide a written report to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2013.

FINDING 2: The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, heard from several providers about the burdensome and sometimes delayed process by which community hospitals bill and receive payments under the three-way contacts. In addition, the existing rate of $750 per day is insufficient to cover the cost to serve higher-need mental health patients.

RECOMMENDATION 2: The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services, encourage the General Assembly to direct the Department of Health and Human Services to work with community hospitals to develop a plan to (i) address delayed payments and (ii) revise three-way contract payment from a single rate model to a tiered rate structure based upon the patient's acuity level. The Department shall submit the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Chairs of the House and Senate HHS Appropriations Subcommittees no later than October 1, 2013.

FINDING 3: Based on current data shared during presentations, the Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, understands that there are critical shortages of qualified mental health professionals in many areas across the State. The Subcommittee heard from two presenters that telepsychiatry is an effective option

to address these shortages. The Subcommittee finds that the shortage of qualified professionals adds to hospital ED wait time, involuntary commitments, and local law enforcement involvement in transport of patients who have been involuntarily committed, and that telepsychiatry may be an effective way to address some of these issues, especially in rural and underserved areas.

RECOMMENDATION 3(a): The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services encourage the General Assembly to direct the Department of Health and Human Services to develop a plan for a statewide telepsychiatry program. The Department's plan should include program costs and rates of payment for telepsychiatry services, and address liability issues related to participation in telepsychiatry. The Department shall submit its plan to the Joint Legislative Oversight Committee on Health and Human Services no later than October 1, 2013.

RECOMMENDATION 3(b): The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services encourage the General Assembly to direct the Department of Health and Human Services to investigate incentives and the removal of unnecessary practice barriers in order to increase the overall supply of psychiatrists, psychologists, and other mental health professionals, especially in rural and underserved areas of the State. The Department shall submit a written report to the Joint Legislative Oversight Committee on Health and Human Services no later than October 1, 2013.

FINDING 4: The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Mental Health, heard from several presenters about the increasing number of military veterans in North Carolina, and that many of these veterans exhibit behavioral health problems associated with Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD). Many of these veterans living in NC are experiencing homelessness, alcohol and other substance abuse problems, and criminal system involvement. The Subcommittee finds that because North Carolina is a military-friendly State and has a large number of veterans living in the State, and that veterans have specific behavioral health care needs, that the State should continue to link veterans to effective and efficient services.

RECOMMENDATION 4: The Subcommittee on Mental Health recommends that the Joint Legislative Oversight Committee on Health and Human Services encourage the General Assembly to require that the Department of Health and Human Services continue to work with the Department of Veterans Affairs and other military groups to (i) increase training for mental health professionals in evidence-based practices designed specifically for individuals who are active or retired military, (ii) increase the numbers of veterans taking advantage of Medicaid and other federally funded assistance programs through targeted outreach through local DSS agencies and identifying veterans in the NCFAST program, and (iii) decrease homelessness among veterans. The Department shall submit a written report to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2013.

APPENDIX

Authorizing Legislation : S.L. 2012-142, Sec. 10.11, as amended by S.L. 21012-145, Sec. 3.4:

EXAMINATION OF THE STATE'S DELIVERY OF MENTAL HEALTH SERVICES

SECTION 10.11.(a) The Joint Legislative Oversight Committee on Health and Human Services shall appoint a subcommittee to examine the State's delivery of mental health services. As part of its examination, the subcommittee shall review all of the following:

(1) The State's progress in reforming the mental health system to deliver mental health services to individuals in the most integrated setting appropriate, without unnecessary institutionalization.

(2) The State's capacity to meet its growing mental health needs with community-based supports.

(3) The process for determining the catchment areas served by the State's psychiatric hospitals, with consideration of both of the following:

a. Factors used in assigning the geographic groupings of local management areas and managed care organizations into catchment areas.

b. Alternatives to the current process for determining the catchment areas served by the State's psychiatric hospitals, including a determination of whether there is a more efficient and equitable manner of assigning hospital catchment areas.

(4) The impact of implementing the 1915(b)/(c) Medicaid waiver and other mental health system reforms on public guardianship services, including at least all of the following:

a. Guardianship roles, responsibilities, and procedures.

b. The effect on existing relationships between guardians and wards.

c. Recommended legislation to support the transition of public guardianship services from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within the Department of Health and Human Services to county departments of social services.

SECTION 10.11.(b) The subcommittee shall report its findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before January 15, 2013, at which time it shall terminate.